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A. That's right.
Q. And who does Mr. Plourde report to?
A. Today, that is -- that changed. So, today it's Andrew Dreyfus.
Q. What is Mr. Dreyfus --
A. He's the executive vice president.
Q. What is he the executive vice president of?
A. He's the executive vice president of health care services.
Q. And who does Mr. Dreyfuss report to?
A. He reports to -- who does he report to? Today he reports to the CEO.
Q. And that's Mr. Killingsworth?
A. That's correct.
Q. Now, what areas does Mr. Dreyfus have oversight over, in addition to everything Mr. Plourde has oversight over?
A. Well, he's only been in the role since -- he has only been in that role since this past fall. So, he's just taken it on relatively recently. He has responsibility for provider

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services, which is Vin's organization. He has oversight for provider contracting and also health care -- health care management.
Q. Who was in the executive VP of health care services position before him?
A. Sharon Smith.
Q. Do you know how long she was in that position?
A. I don't know when she was an EVP, but she was a senior vice president prior to that. Essentially, she -- in 2001 there was a big organizational change, and so, that's when Sharon came into that role. She was given that title and took on the provider side of the house. Prior to that, Sharon was in a different side of our business.
Q. What side of the business was she in?
A. Customer, customer relations -- we call member services.
Q. And where was Mr. Dreyfus before he came to this role?
A. He wasn't with the company. He was with

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a separate foundation, Blue Cross Blue Shield Foundation, and then prior to that, he was with -- I don't actually know where he was prior to that.
Q. Now, let's go to some more documents.
(BCBSMA-AWP-10605-10607 marked Exhibit Fox 004.)
Q. Now, I'd like to draw attention to the third page of that document, please. So, this is a memo to physicians that are part of the BC 65 network, right?
A. Yeah, that's what it says.
Q. Now, in the second paragraph it says, "We plan to update our Blue Care 65 physician fee schedules effective March 1st, 2004 to reflect Medicare's 2004 fee schedule changes." Do you see that?
A. Yes.
Q. And it says, "Because Medicare's 2004 update increased physician payments by 1.5 percent, our Blue Care 65 physician fee schedules will reflect the same increase." Do you have an understanding as to which parts of the Medicare

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physician payment schedule that's referring to?
A. Not specifically. We enter -- we issue this communication every year at around the same time. So, whatever changes have been made on the physician fee schedule side for Medicare, to the extent that they apply to our business, we send notice and make those changes.
Q. Well, have a look at the next paragraph. The first sentence notes that, "Medicare has said it's going to reduce its payment on office-administered drugs from 95 to 85 percent of AWP." Do you see that?
A. I do.
Q. And then it says, "We will also follow Medicare's lead on increasing the fees for infusion, injection, and chemotherapy admin codes." Now, my question is, was Blue Cross Blue Shield of Massachusetts just increasing the admin fees following Medicare, or was it also reducing the drug reimbursement?
MR. COCO: Objection.
A. I have no idea. We just produce the

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communication. I don't always have the underlying detail to what it is specifically.
Q. Well, you see the first page of this document reflects that this is from or related to a Provider Financial Strategy Work Group Steering Committee meeting.
A. Lots of communications are brought to that work group before they go out.
Q. Do you recall this issue being discussed in any meetings in which you participated?
A. I don't recall that specific issue, no.
Q. Who would know the answer as to whether or not the BC 65 reimbursement was changed from 95 percent of AWP?
A. Mike. I'd say Mike Mulrey. Mike is who I would call.
Q. Anyone else?
A. No. Mike is all things fee schedule.
MR. MANGI: Let's mark this next exhibit as Exhibit Fox 005.
(BCBSMA-AWP 10608 marked Exhibit Fox 005.)

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Q. Now, Exhibit Fox 005 are minutes from another meeting of the Provider Financial Strategy Work Group from January 19, '04.
A. That's what it looks like.
Q. And you'll see that you are one of the people attending that as listed on this document.
A. That is what it says.
Q. Now, I'd like you to review, please, the paragraph entitled "Emergency Medicine Physician Recontracting," and let me know when you're done.
A. (Witness reviews document.) Sure. I'm familiar with that.
Q. Do you recall this issue?
A. Yes, I do.
Q. What was this issue, and how did it come up before the Provider Financial Strategy Work Group?
A. We -- this -- emergency medicine physicians typically, as a specialty, did not contract with health plans, in particular because for the services they rendered, since they were emergent services not subject to referrals or

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prior authorizations, lots of these physicians would not have a contract, and health plans would have to pay them charges. And over time, as we started to make changes in our fee schedule, we felt it was the right opportunity to really go after the segment and really try to understand why they weren't participating and try to get the payment levels to a place where they were competitive. That's what this is.
Q. Okay. Now, what do you mean when you said you wanted to get payment levels to a point where they were competitive?
A. Well, the physicians would tell us that our rates were very low compared to other health plans, compared to other markets, and they, you know, they were looking for us to be more competitive with our fees.
Q. So, they were unwilling to contract at the levels that were currently being offered and were referring to -- were pointing to other health plans paying a better rate as saying that's what they wanted to contract?

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MR. COCO: Objection.
A. One factor.
Q. What was the -- what was the resolution of that issue?
A. Well, I mean, there were several. There were changes that came along in Medicare as far as the RBRVS methodology changed a bit to recognize the specialty. We better understood their malpractice issues. So, we did create a multiplier for this specialty to really better recognize the mix of services that they were doing. So, we made some fee schedule increases, again, targeted to this specialty, as we talked about earlier, and we proceeded to get more of the physicians into our plan.
Q. What was the multiplier that was applied?
A. I couldn't even remember that. I don't know.
Q. Looking at Exhibit Fox 005, the Provider Financial Strategy Work Group decided to increase the fee schedule by 20 percent, right, in June of

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'04?
A. I see that, so that might have been right.
Q. And then there was another schedule to be considered later that year. Was a further increase carried out?
A. I don't recall specifically, but I know there -- I mean, this is -- there were a couple of adjustments made specifically for emergency medicine physicians, but I -- I don't remember -- I don't know if -- I don't know specifically what we did after this, but --
Q. To what extent is this or similar themes present in negotiations with other specialty groups? Specifically, to what extent do they raise the rates that other health plans are paying them as a basis for negotiating terms?
MR. COCO: Objection.
A. Frequently. I mean, again, it's a -- they're -- they're looking -- I mean, physicians are looking -- well, first of all, they want to get reimbursement that they think is fair, and

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they also have an interest in -- well, they have an interest in having fair reimbursement. So, it is not atypical for a physician to come to a health plan and say the other guys are paying me more. I want you to pay me more. It doesn't mean it's always right. And we certainly take it as one factor.
Q. Do these various physician groups provide specific information on what other plans are paying them?
A. Not directly.
Q. Presumably that would implicate confidentiality concerns in their relations with other health plans, right?
MR. COCO: Objection.
A. I don't know what their relations are with other health plans, but if they took our fee schedule and gave it to another health plan, that wouldn't be -- that wouldn't be acceptable.
Q. Now, when a physician group makes this sort of a common complaint to BCBS of Massachusetts, how does BCBS of Massachusetts

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determine what's the right amount of increase?
MR. COCO: Objection.
A. There is no -- I mean, there's no science to it. I mean, I think there are a couple of things. We may see -- they may give us blinded information where they say, here's Health Plan A; here's Health Plan B. We could ask for an independent third party to review and validate those on a confidential basis so that someone else is verifying those terms. We could do that. We could look at industry data.
We could look at, you know, different points of reference in the -- whether it's inflation, whether it's, you know, different segments of the economy to see if there's any -- anything that we could draw from that. But it's difficult, so you do the best you can with the information that you have.
Q. And after a change has been made using the various inputs that you describe, how does BCBS of Massachusetts determine whether or not it's hit upon the right formula?

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MR. COCO: Objection.
A. Again, I don't think there's a big science to it. I think it's just if -- if whoever is raising those issues feels that the steps that we've taken are sufficient, then they'll typically tell us. And if they feel that they're not, they'll typically tell us that, also.
Q. Is one factor that reflects whether or not the changes has been suitable whether or not physicians then join the network at that rate?
A. It depends on -- it depends. It could. In the instance that we're talking here, this emergency medicine group, clearly, it did. But they also had control, if you will, of a set of services that were probably putting them in a different situation than another group of physicians who had less -- less ability to direct patient volume than others.
Because we did this for this group, this is certainly not typical of our strategy.
Q. What's not typical? I'm sorry. I lost your chain for a moment.

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A. To take a group of physicians and to do something specific for that group of physicians, to change their methodology for reimbursement, to apply a different factor is not typically what we do.

What we typically do is apply a standard conversion factor across the board, unless we're negotiating a group-specific contract.

Q. In the case of the emergency medicine physicians, do you recall -- I understand you don't know whether or not a further price change was made -- but do you know whether or not the problem was resolved?

MR. COCO: Objection.

A. I don't know if the problem was resolved, but our participation rates are higher, and so, I would say that the factors that they raised apparently have been solved to their satisfaction.

Q. Now, I believe that is an entry for "BC 65 Drug Change Impact." And the second sentence of that says, "If BCBSMA were to follow Medicare's

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lead and implement the same changes for BC 65, the changes would effectively decrease physician payments by approximately $200,000 annually. Deb will discuss this issue with Jan Cook to determine if Jan has committed to a dialog with oncologists prior to external communication of the change."

Do you recall this issue being discussed in the Provider Financial Strategy Work Group?

A. I remember the conversation, yeah.

Q. Why was the input of oncologists being considered as or sought as part of this evaluation?

A. Again, I think, as I said earlier, anything that we do that negatively affects any group of physicians in our network, our position is to go out and talk to that group. So, if we're going to affect their payment, it would be good to have a conversation with them prior to doing that. We're not required to do it, but --

Q. And that would be true of this BC 65? Similarly, it would also be true of the contemplated move to ASP we looked at in Exhibit

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Fox 003?

MR. COCO: Objection.

A. Not specific. It doesn't have to be specific -- those specific items. It could be at a higher level. So, whether we did or didn't, I mean, I'm not aware of those conversations.

MR. MANGI: Let's mark Exhibit Fox 006.

(BCBSMA-AWP-10609-10610 marked Exhibit Fox 006.)

Q. Now, this is another Provider Financial Strategy Work Group meeting minutes from April 26th, 2004 where you're one of the people attending, right?

A. That's what it says.

Q. Now, I'd like you to look at the second paragraph titled "Universal Fee Schedule." It says, "Currently, all physicians except Children's and Partners get paid off of one of BCBSMA's fee schedule (Children's has a separate fee schedule; Partners has a multiplier of our fee schedule with a withhold.)" Now, we've spoken about multipliers earlier in the context of individualized

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negotiations. What is the separate fee schedule for Children's that is being referred to here?

A. For groups like this where they are large, they have a particular command of a segment of the provider population, they typically do not -- they do not accept standard fee schedules from any payer. And so, what they will typically do is negotiate specific rates or methodologies that apply in general to their population. Not at the specific code level, but just in general. If our multiplier is 10, then they'll negotiate some number that's different than that, for example.

Q. What is Children's?

A. Children's -- well, Children's is a hospital in our network.

Q. What is the full name of that hospital?

A. It's Children's Medical Center. Children's Hospital.

Q. Now, what was the separate fee schedule that Children's had? Is that something that it provided to BCBS of Massachusetts?

A. Well, in this context they're talking

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about the Children's Physician -- which is a physicians' foundation -- it's a foundation of physicians. So, this was a negotiation that we entered into with Children's. It's a contract. We have a contractual relationship across our entire book of business, and they negotiate the payment parameters for their physicians.
Q. Now, are these physicians practicing in a hospital setting, or is this a physician office setting?
A. Both.
Q. What is the basis on which -- withdraw that. Is their separate fee schedule, does that also differ from the standard drug reimbursement methodology that BCBS applies to all its physicians?
A. It would be the same. So, if we -- if we include or exclude drugs, then it would be the same. It would just be at a different rate.
Q. What is the rate specified for drugs at the Children's facility?
A. I don't know that there's a separate

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negotiated rate for drugs. We just have an overall payment multiplier for Children's, and it applies for all services that they bill.
Q. Is it just a multiplier, or is it a separate fee schedule?
A. Well, it's -- it's a separate multiplier which creates -- if you want to call it a new fee -- we -- I mean, you're talking internal language of the plan. We call it a separate fee schedule, because it's not a standard fee schedule. But all that we're doing is taking our standard fee schedule, negotiating a multiplier, and that then creates another fee schedule.
Q. Maybe it's just inartful language in the minutes; but it appears to me when this says, "Children's has a separate fee schedule; and Partners has a multiplier of our fee schedule," the minutes seem to suggest those are two separate things. Is it your testimony they are actually the same thing?
A. Well, they may be different. They may be different, but the net effect is the same.

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Children's has a separate fee schedule. The way it was built on our system was a multiplier which creates different rates.
Q. So, both of them are multipliers?
A. Yeah. I'd call it that.
Q. It's not a situation where Children's provides an entirely different fee schedule or negotiates an entire different fee schedule with Blue Cross Blue Shield of Massachusetts?
A. Well, they have different rates, clearly -- they have different rates, but the basis is largely the same.
Q. Now, it continues, "Our major competitors do not pay a flat schedule, but rather make strategic differentials five to ten times a year."
A. Uh-huh.
Q. What are these strategic differentials that are being described there?
A. Similar to what we just talked about with emergency medicine. We decided to do something strategically different with that group

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of providers. Other health plans may decide to do something similar, or they may decide to go after a particular group in a particular region for their own reason. But I mean, largely, we all have the same physicians in our network, so --
Q. So, "strategic differential" means treating a particular group of physicians differently --
MR. COCO: Objection.
Q. -- is that correct?
A. Well, I don't think -- I don't think I said that. I think it -- are you saying specific to Blue Cross or the -- I can't speak to the other payers.
Q. I'm trying to understand what the term "strategic differentials" means --
A. Sure.
Q. -- as a lawyer with little understanding.
A. It would -- I would read that to say a strategic differential would mean that they will want to work with a particular doctor or groups of

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physicians to change their reimbursement for their own strategic purposes.
Q. Okay.
A. So, again, since we all have the same physicians in our network, and we largely all reimburse the same way, there may be a plan that wants to treat one group different than others, for some strategic reason.
Q. How far back in time have Blue Cross Blue Shield of Massachusetts competitors been making strategic differentials?
MR. COCO: Objection.
A. Again, I can't speak to that. I don't know. Don't know.
Q. Based on your -- how far back are you aware of competitors making such a "strategic differentials"?
A. I tell you, until I've read it in the minutes, I've not really even heard it referred to as that. So, I'm going to say that I don't know, because I've not really heard it discussed in that context.

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Q. Now, how often does Blue Cross Blue Shield of Massachusetts update its own fee schedule?
A. That's typically annually.
Q. And what's the process whereby that update is carried out?
A. As I may have mentioned earlier, we will understand what the Medicare -- or what the methodology is that's out there. RBRVS, what is it? When is it available? Then we will take it in house and understand the things I mentioned before, what's the impact on the CPI or DRI or different clinical medical indices? And then we will look at the available pool of money that we have to fund fee schedule changes, and we will run some modeling scenarios, and we'll bring them to this group, take a look at it, and communicate it.
Q. Now, it seems to me there are two separate stages that you're describing. There's the analytical stage, and then there's the implementation stage. Is that a fair statement?
MR. COCO: Objection.

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A. I don't know that I'd separate them. Its really all tied together. We can't --
Q. I understand that. I'm merely trying to --
A. Sure.
Q. -- get an understanding as to what's involved. They may overlap, but there's a process of analysis, and there's a process of implementation, right?
MR. COCO: Objection.
A. I would say in between that there is an analysis, there is a decision that needs to be made based on the analysis, and then there's an implementation.
Q. Fair enough. Now, in this annual update process, how much time is typically devoted to the analysis stage?
A. I can't --
MR. COCO: Objection.
A. I can't speak to that, because I'm not doing the analysis. So, I'm typically -- I see the results of the analysis, so I wouldn't even

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know.
Q. Who's involved in the analytical stage?
A. Some of the documents that you shared earlier are some of the folks that we've already talked about would typically bring the analysis forward. People like Mike and his group that would kind of value -- since, again, they're responsible for the fee schedule, then they would typically do that analysis.
Q. Is that something that's done out of the Provider Financial Strategy Work Group?
A. Well, the work group isn't a body. It's just a group of individuals. No, it's done out of our finance area.
Q. And after the decision is made -- well, withdraw that. Who makes the actual decision then on what changes to implement?
A. The Provider Financial Strategy Work Group makes the recommendation. That recommendation then goes to senior management, essentially, but this work group is really cross-representative of different areas in the company.

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So, there's really not a lot of discussion that goes on once it leaves this group. So, it goes up to senior management for their -- for their view, and we then implement it.
Q. And after the decision is made, how long does the implementation take?
A. Well, there's a couple of things that happen. There's the actual updating of our system, and there are lots of operational issues and challenges with that. So, there's lots of people that are involved in that and doing all of that. And then we -- my area's responsible for generating the communications and explaining it and talking to physicians about it.
Q. And by "updating the systems," you're talking about implementing changes to the fee schedule and things like that, right?
A. Yeah.
Q. Claims processing system, essentially?
A. Well, it wouldn't -- it's the actual -- it's actually updating the rates on our system of tables or things like that.

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Q. How long does that process take?
A. It -- well, I mean, we typically -- we allow -- we allow 90 days in general for -- we communicate these changes 90 days in advance of them. In some instances, longer than that. It could be six months in advance, because it sometimes can take that long to update thousands of codes.
Q. Now, the changes that are done on an annual basis, these involve some changes to specific codes where there are individualized negotiations, is that correct?
MR. COCO: Objection.
A. Not typically, no. It's typically just the -- no. It's the updating of multipliers. It could be -- there might be codes which are not based on RBRVS which need to be reviewed. I mean, it's really a lot of operations, because our products -- the way our system is configured, I guess.
Q. Well, the multipliers stem from different negotiated arrangements, right?

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MR. COCO: Objection?
A. No, the multipliers are, largely stated -- as I mentioned before -- the multipliers are across our entire book of business. And then if we have any negotiated differences off of that, those would be implemented separate. But that's a small portion of our --
Q. Are those implemented as part of the same process?
A. Not necessarily. They might be on different time frames. They may not be. They might not be tied to when these updates go in.
Q. The general timeline is approximately 90 days for that updating phase?
MR. COCO: Objection.
A. At least. I mean, in many instances, it's longer than that.
Q. But that's a process that's carried out on an annual basis.
A. There is -- from decision -- let me back up. From decision to implementation is longer than 90 days. From decision to implementation

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could be six months. We provide notice not less than 90 days in advance. And again, so that we build enough time to actually do all of the changes.
Q. But my question was, the process that we have been talking about, updating the fee schedules, making these changes is, this is done on an annual basis.
A. That's correct.
Q. Okay. How long has it been done on an annual basis?
A. Changing our fee schedule?
Q. Uh-huh.
A. The -- we review and update the fee schedule since we've gone to the RBRVS methodology in 1995. Not every year have we actually increased the fee schedule. There may have been years where we didn't. But we've reviewed it on an annual basis.
Q. Now, does Blue Cross Blue Shield of Massachusetts have the ability to ask providers what they're paying to acquire physician-

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administered drugs?
MR. COCO: Objection.
A. Say that again. Do we --
Q. Have the ability to ask providers what they're paying to acquire physician-administered drugs?
MR. COCO: Objection.
A. Well, having the ability versus -- versus do we ask, I think, are different questions.
Q. They are. I am asking you do you have the ability?
A. I don't know. I don't know that we have the ability to. I mean, I have the ability to ask a physician anything I want, but I don't know that it would come up in the normal course of business.
Q. Well, my question is, is there anything that you're aware of preventing you from asking a physician what he pays to acquire drugs, if you wanted to gather that information?
MR. COCO: Objection.
A. I don't know that that's, frankly, in

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the scope of our relationship with a physician to ask what they're purchasing. I don't ask a physician what they're paying for durable medical equipment that's in their office. So, I don't know that I would do the same there.
Q. Are you aware that your department has done so in the past?
MR. COCO: Objection.
A. No.
Q. Let me show you a document.
(BCBSMA-AWP-00048-51 marked Exhibit Fox 007.)
Q. Now, if you look at the second e-mail on this page, that's from Lisa Gorman. Do you see that?
A. Yeah, I do.
Q. Lisa Gorman is one of the people who works for you, right, in the provider relations department?
A. She is.
Q. Do you see the date on that e-mail is August 23rd, 1999?

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A. Yeah.
Q. Okay. Now, I'd like you to look at the second paragraph there. It says, "Secondly, I was not shy in my meeting with Doctor Kagan about discussing how much he's really paying for the chemo drugs." Now, does this refresh your recollection as to whether or not you have the ability to ask providers what they pay to acquire drugs?
MR. COCO: Objection.
A. No. I mean, first of all, I've not seen this document before. I'm not on this e-mail. You know, I can't -- at this time -- I don't even think Lisa was a director at this time. Lisa was provider relations manager in the field during this time. During conversations that -- in fact, I don't even know that Lisa was working for me at the time, but she may have been in my role as director. But conversations that my staff have with physicians, you know, I don't tell them what to say.
Q. Well, we can agree, looking at this,

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can't we, that at least one person in your department has had a conversation with the physician where they were not shy about asking the doctor what they're paying for chemo drugs.
MR. COCO: Objection.
A. I'm reading the e-mail that you're looking at. So, again, this is the first time I've seen it. I'm not going to -- I can't tell you what Lisa was thinking or what she did or didn't do.
Q. Well, do you have any reason to think she's lying in this e-mail?
MR. COCO: Objection.
A. No, I don't think anybody would be lying. But again, I'm not going to try to read Lisa's mind as to what she meant when she was writing this -- writing this e-mail.
Q. Okay. Let me ask you to assume for the moment that she's telling the truth in this e-mail about the conversation that she had with Doctor Kagan. Would her asking the doctor what he was paying for chemo drugs be something that would be

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contrary to any BCBS of Massachusetts policy that you're aware of?
MR. COCO: Objection.
A. I think you should ask Lisa that yourself.
Q. Well, you're her boss, so I'm asking you.
MR. COCO: Objection.
A. Again, there is not a policy in place at Blue Cross and Blue Shield to engage physicians in discussing payment rates.
Q. That's not my question. My question is, is there a policy at Blue Cross Blue Shield of Massachusetts prohibiting people in your discussion, such as Ms. Gorman, from having a conversation with a doctor asking them what they're paying to acquire drugs?
MR. COCO: Objection.
Q. Are you aware of any such a policy?
A. These things aren't -- there are no policies for these things.
Q. Okay.

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A. These are conversations that people have with physicians every day.
Q. Now, earlier in that e-mail -- I'd like you to read the first paragraph and let me know when you're done.
A. (Witness reviews document.) Yeah, that's it.
Q. Now, Ms. Gorman here says, "I wanted to emphasize the fact that Doctor Kagan," who is the oncologist being discussed here "-- may be paying a different rate than his colleagues and vice versa." What do you understand Ms. Gorman to be referring to?
MR. COCO: Objection.
A. I have no idea. Lisa's got a relationship with these physician. I'm not aware of these conversations. I don't know what she's referring to. No, I don't.
Q. Well, let me ask you this: Are you aware of the fact Ms. Gorman recounts here that different doctors may be paying different rates for drugs?

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MR. COCO: Objection.
A. It's not my understanding.
Q. Is it your understanding that all doctors pay exactly the same price for drugs?
A. It wouldn't be my -- it wouldn't be my understanding that there would be different rates that were being paid.
Q. Okay. So, as a consequence, it's your understanding that all doctors pay exactly the same rate for drugs?
MR. COCO: Objection.
A. No, I mean, it's hard to make those statements, because not all fees are the same for all services. So I --
Q. I'm not asking about reimbursement.
A. Yeah.
Q. I'm not asking about Fee For Service. The question's a simple one. Ms. Gorman says that Doctor Kagan may be paying a different rate than his colleague and wants to emphasize that fact?
A. Uh-huh.
Q. My question is, is it your

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understanding, like Ms. Gorman, that doctors paid different rates to acquire drugs, or is it your understanding that all doctors pay the same to acquire drugs?
MR. COCO: Objection.
A. No, it's not -- my understanding is that physicians are paying the same amount.
Q. What's the basis for your understanding that all physicians are paying the same amount to acquire drugs?
A. The absence of anything contrary to that.
Q. So, you're saying you haven't seen any evidence that would cause you to think otherwise.
MR. COCO: Objection.
A. No. No. This is the first time I've seen this e-mail, so --
Q. What about the OIG report that we looked at earlier, does that give you cause to think maybe otherwise?
MR. COCO: Objection.
A. No, because prior to today, I hadn't

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seen that report either.
Q. Okay. But you've seen it now. Does it give you cause to think otherwise now?
MR. COCO: Objection.
A. No, not at all. There's lots of things that come out of OIG that I wouldn't agree with.
Q. When the OIG is saying that AWP is not a reliable indicator of the cost of a drug to physicians, is that one of the things that come out of OIG that you don't agree with?
MR. COCO: Objection.
A. I have no opinion on it. Again, I read it this morning, I understand what it says, I'll process that information.
Q. Can we agree that what Ms. Gorman is emphasizing here is different to your own understanding?
MR. COCO: Objection.
A. I would say it's different than my understanding.
Q. And we can agree that your view and Ms. Gorman's views are inconsistent with each other?

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MR. COCA: Objection.
A. I would say that Lisa has her opinion, and I have mine.
Q. I understand that.
A. And it's okay to disagree.
MR. COCO: We've been going about an hour. Is this a good time?
MR. MANGI: Let's mark this as Exhibit Fox 008.
(BCBSMA-AWP-12489-12494 marked Exhibit Fox 008.)
Q. Now, the top left of Exhibit Fox 008 has your name written at the top of the page, right?
A. Yeah.
Q. So, this is something that's been printed out from your e-mail system?
A. Presumably.
Q. Would you turn -- can you see the numbers on the bottom right that starts with BCBSMA-AWP?
A. Yes.
Q. We refer to those as Bates numbers. I'd like you to turn to the page Bates numbered 12493, please. You'll see an e-mail for which the header actually starts on Page 12492.

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A. Uh-huh.
Q. You'll see it's from Jan Cook, dated July 19, 2002 to V. DuLong at MMS Document, and you're one of the cc e-mails. Do you see that e-mail?
A. Yes.
Q. MMS is one of the societies, right?
A. MMS is Mass. Medical, yes.
Q. I'd like you to turn to No. 6 and Ms. Cook's e-mail, the subject is "Inadequate Chemo Reimbursement: We reimburse, as Medicare does, AWP minus 5 percent. We understand in some situations this is very fair to practitioners, and in others, it may be less advantageous. We generally feel this process evens itself out." What was your understanding of what Ms. Cook was saying when you received this e-mail?
MR. COCO: Objection.
A. Well, I don't think I received the e-

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mail. I think I was copied on it. I'm on this e-mail. One, I mean, I've gone to meetings at MASCO but two, I think -- you're pointing out -- I'm looking at other bullets where this would be particular to me about how we would communicate to physicians. So, I mean, I don't have any recollection of this particular statement, and I don't think I had conversations with Jan about it.
Q. Okay. Well, let me ask you to read it now, and tell me what's your understanding of it.
A. As I said earlier, I'm not going to put myself in someone else's shoes.
Q. I'm not asking you to. I'm asking you what's your understanding of this e-mail of which you were copied and of which you received a copy?
MR. COCO: Objection.
A. I don't -- I have -- my understanding of all these other bullet points that I'm looking at, which is probably what I would have focused on.
Q. Well, respectfully, let me rephrase the question. I'm asking you to look at No. 6. I'm asking you to read it now. And I'm asking you to

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tell me what you understand it to mean.
MR. COCO: Objection.
A. (Witness reviews document.) I read it and I see what Jan is saying. I don't know that I'm the "we" in "we." Just 'cause I'm copied on the e-mail doesn't mean I'm "we."
Q. "We" is the Blue Cross Blue Shield of Massachusetts, isn't it?
A. Right. But what I'm saying -- I understand what it says.
Q. Okay. Since you understand what it says --
A. Yeah.
Q. -- let me ask you this: It says, "In some situations, AWP minus 5 is very favorable to practitioners --"
A. Sure.
Q. "-- and in others, it's less advantageous."
A. Uh-huh.
Q. What do you understand that to mean?
MR. COCO: Objection.

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A. At a global -- at a global level, yeah, that the reimbursement -- well, no, actually -- (Witness reviews document.) I'm not even going to speculate, because I don't -- to be honest with you, as I read this, I don't even know.
Q. So, when you said earlier you understood what this meant, are you now changing that testimony?
A. Yeah, I'm actually rereading the last sentence: "In general, we feel that this process ... If this isn't the case --" I don't know if she means AWP reimbursement or if she's talking -- I don't know what she means by "In some instances it's advantageous, and in other instances --" I don't know specifically what she's referring to in that bullet.
Q. Well, let's follow her logic. She says that, "We reimburse as Medicare does at AWP minus 5 percent." Do you see that?
A. I do.
Q. Now, how would that be more favorable to a physician in one setting and less favorable to

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another physician?
MR. COCO: Objection.
A. Yeah, I don't know.
Q. Isn't the only way in which that would be true if the physicians were acquiring the drug at different prices?
MR. COCO: Objection.
A. I wouldn't necessarily draw that conclusion.
Q. Well, would that conclusion be consistent with what Ms. Cook is saying here?
MR. COCO: Objection.
A. Well, I would suggest that you ask Doctor Cook. I'm not going to --
Q. I did that. But I'm asking you now.
A. I'm not going to --
MR. COCO: Objection. Sorry.
A. I don't know.
Q. Okay. Do you have another explanation for what this paragraph means?
MR. COCO: Objection.
A. No, I don't. And I would probably have

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been focusing -- my issues really would have been more focused on the top set of bullets than the bottom, 'cause they really apply to what I'm doing.
Q. When communications are sent in to Blue Cross Blue Shield of Massachusetts from providers, is that -- do those communications come to your department?
A. Where are you reading that or are you --
Q. No, I'm asking you.
A. Oh. Well, they could come into individuals in my department, sure.
Q. Well, let me ask you to turn to the front page of the e-mail.
A. Uh-huh.
Q. In the second e-mail from Nancy Marotta, it says towards the middle of the e-mail, "If you receive a paper claim, and the invoice is attached, then price the drug to pay, whichever is less, AWP minus 5 or the amount of the invoice." Is that generally true of BCBS Massachusetts reimbursement, i.e., is it the lesser of 95 of AWP

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or the bill charge, or is this a unique situation that's being referred to?
MR. COCO: Objection.
A. I don't know. I mean, I'm not -- again, I'm not in the claims department, so I don't know. Nancy was in the claims area, so --
Q. Well, it says above that, "Steve has volunteered to take care of the communication to the oncologists." Do you see that?
A. I do.
Q. So, presumably you understood what you were supposed to communicate to the oncologists, right?
MR. COCO: Objection.
A. I think what I was asked to communicate to the oncologists is that if there's not a code listed for the drug that they're billing, then they have to tell us what they're billing for so we'd know what to pay them.
Q. And you weren't communicating any of the other points in the e-mail below?
MR. COCO: Objection.

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A. I don't know. I'd have to see what we ultimately produced. But again, my view of this would have just been, what do you want me to communicate? Tell me what you want me to communicate, and we communicate it.
Q. Have you searched your files for documents relative to this litigation?
A. Yes, I think this is actually one of mine, because that's my writing (indicating).
Q. What did you search for?
A. I searched for every file. I did a search on my system, and I did a search in my files for all of these subjects.
Q. Which subjects?
A. Whatever we were asked to look for, AWP, pricing, a bunch of different things like that. I -- so, we did a search on the system, pulled off any communications we had, and then, you know, searched through files and looked at anything that I would have had in my file, to the best of my knowledge.
Q. Did you provide any -- collect

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communications from providers going to the amount of reimbursement that did not specifically mention the word "AWP"?
MR. COCO: Objection.
A. I looked for every -- if it's a paper communication, then I would have gone through all my files to find paper communications that I could put my hands on. I mean, again, I have thousands of files. And I've been working there a long time, so it's --
Q. Did you go through all those files?
A. I went through all my files.
Q. My question was, did you look for communications from oncologists complaining about the amount of reimbursement that did not specifically mention the word "AWP"?
MR. COCO: Objection.
A. I would have looked -- if I had a file that was an oncologist file, then I would have handed that file over to counsel.
MR. MANGI: Let's mark this document as Exhibit Fox 008.

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MR. COCO: I really do need to take a break.
MR. MANGI: We can do that now. Exhibit Fox 009. I'm sorry.
(BCBSMA-AWP-00054 marked Exhibit Fox 009.)
(Recess was taken.)
Q. Now, Exhibit Fox 009 is -- Exhibit Fox 009 is a series of e-mails. I'd like to draw your attention to the middle e-mail, which is from Mary Powers to Anne Meneghetti, dated August 18, 1999. Do you see that?
A. I see it.
Q. Who is Ms. Powers?
A. Mary worked for us in medical policy administration.
Q. Did she report to you?
A. No. She reported to Anne, I think.
Q. And what was Anne's title at that time?
A. Anne was one of our medical directors.
Q. And Ms. Powers here says to Ms. Meneghetti at the end of that e-mail, "I always

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thought that the oncologists bought in bulk for most drugs and therefore received a discounted charge from the pharmaceutical companies. Maybe not. Thanks." Do you see that?
A. I do.
Q. Now, is that consistent or inconsistent with your understanding of what oncologists pay to acquire drugs?
A. I don't -- I mean, I don't know -- I have not seen this before. I don't know what Mary's referring to, but -- I mean, I understand that physicians don't buy drugs one at a time. So, I assume that physicians are buying more than one drug at a time. I don't know -- I mean, I wouldn't get -- this is Mary's world more than mine. Her terms, "bought in bulk --" I wouldn't take it all the way further, but I would assume physicians buy drugs more than one at a time. I would agree with that.
Q. Referring to where she says, "I always thought that oncologists bought in bulk for most drugs, and therefore, received a discounted charge

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--"
A. Uh-huh.
Q. -- that's the section that I am focusing on. Is that consistent or inconsistent with your understanding of the prices at which oncologists buy drugs?
A. I'm not -- I'm not aware of that last statement. I don't have anything that -- I don't have anything that would lead me to believe that.
Q. Well, you testified earlier that you thought all oncologists buy drugs at the same price, right?
A. Yeah. Yeah.
Q. And that is inconsistent with the idea of there being volume-related discount, right?
A. Yeah, I would agree.
Q. So, we can agree that Ms. Powers' position as stated in this e-mail is inconsistent with what you stated earlier in the day.
MR. COCO: Objection.
A. Well, I -- again, I know what I said. I don't know what goes into her -- you know, it's

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hard to read people's mind in e-mails that are six or seven years old. I wouldn't agree or disagree. I'd just say it's different. Again, I'm not on this e-mail chain, so I don't know what they're trying to get at.
Q. Now, if Blue Cross Blue Shield -- and we're done with that document. If Blue Cross Blue Shield of Massachusetts decided that it wanted to get more information on what the physicians are paying to acquire drugs that they administer in their offices, would it have the means to do so?
MR. COCO: Objection.
A. Well, I don't know what you mean by would we have the means to do so? What is that?
Q. Can you do it?
MR. COCO: Objection.
A. I have no idea.
Q. Do you know if there are any ways in which to get that information?
MR. COCO: Objection.
A. I'm -- there's not -- there's no manual I can go to that says, Here's how it -- you know,

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no. I mean, I don't know how you'd do that.
Q. Well, let me show you another document.
MR. MANGI: Let's mark this as Exhibit Fox 010.
("Hooked on Drugs" marked Exhibit Fox 010.)
Q. Are you familiar with the publication Barron's?
A. I mean, know it's an -- I mean, I know what it is. I don't read it, but I'm not tremendously familiar with it.
Q. You know it's a publication?
A. It's a publication.
Q. You'll see the date on this article is June 10, 1996.
A. I see that.
Q. Okay. Now I'd like to draw your attention to the table that's situated in the bottom of the middle columns and the heading is, "AWP, ain't what's paid." Do you see that?
A. I can't really read it. If that's what you say it says, then I'll --

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Q. Let me show you where I'm reading. Right there (indicating).
A. Okay. Yeah.
Q. And have you ever heard AWP referred to as "ain't what's paid" before?
A. No, I've never heard of it. Oh, AWP, ain't what's paid. I get it. No, I haven't.
Q. It says below that, "A sample of drugs whose published average wholesale price is wildly above the wholesale price available to almost any buyer." Do you see that?
A. Now, where are you?
Q. It's directly under what we just looked at.
MR. COCO: Right here. The first sentence (indicating).
A. Oh, "sample of -- is wildly above --" okay.
Q. You'll see in the table underneath, as that line would suggest, there are different drugs listed, their use, their maker, AWPs, wholesale prices, and the percentage of which the actual

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prices are under the AWPs. Do you see that?
A. I do.
Q. Okay. Now, I'd like to draw your attention the fourth column, which is a column all the way on the right, and the first full paragraph, it says, "For about 300 dose forms of the drugs, Barron's got the AWPs from the Redbook and the Bluebook. Then we collected current quotes from price lists from several leading wholesalers specializing on sales to doctors, HMO health firms, nursing HMOs, and hospitals." Do you see that?
A. Yeah, I see it.
Q. So, you understand looking at that in the table how Mr. Bill Alpert, who is the Barron's reporter who wrote this article, went about collecting this information, right?
MR. COCO: Objection.
A. No, I would say no. One, I've not ever seen this. I've not read -- you've given me lots of good reading material that I'll follow up on, but I would have to spend time reading this entire

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article to understand what it is he's trying to say.
Q. Okay. Let me ask you to assume that the way in which Mr. Alpert collected the information that he lists on the table is using the methodology he describes at Column 4, which is to collect current quotes and price lists, okay?
A. Okay.
Q. I'm going to ask you to assume that.
A. Okay.
MR. COCO: I'll object.
Q. Would that sort of an inquiry be something BCBS of Massachusetts could do if it chose to do so?
MR. COCO: Objection.
A. Not necessarily.
Q. Why not?
A. I mean, I -- one, you know, I'm not going to -- I can't speak for everybody in the corporation. So, whether -- you know, an article printed in 1996, there's lots of articles printed in publications that we could refer to. So, I

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mean, I'm not going to assume that we could take this and do our own analysis similar to this. I don't know that we could.
Q. Well, respectfully, you haven't really answered my question. I'm asking about you as someone in the provider relations department.
A. Could I have done this?
Q. Right.
A. No.
MR. COCO: Objection.
Q. Why not?
A. I don't have a Redbook. I don't know what a Bluebook is. It's not what I would do in my job.
Q. Okay. Let me ask you this: If you had -- are you aware that Redbook is publicly available; that it's a subscription service you can buy?
A. Vaguely.
Q. Let me ask you to assume that to be true.
MR. COCO: Objection.

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A. Okay.
Q. You assume Redbook is publicly available. If you wanted to know what the actual acquisition costs were for drugs, is there any reason why you couldn't make the same phone calls and obtain the same price lists as a reporter from Barron's did in 1996?
MR. COCO: Objection.
A. No, and this part of our reimbursement is miniscule compared to a lot of the other reimbursement work that I would do. So, I would say no, because I wouldn't necessarily -- I mean, first of all, I wouldn't -- I wouldn't know that Redbook is publicly available. You are telling me that now.
Q. Okay. Respectfully, you still haven't answered my question. My question is, if you wanted to collect this information, is there any reason -- is there any reason why you could not have done the same thing this reporter did by collecting price quotes from price lists? Is there any reason you couldn't have done that?

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MR. COCO: Objection.
A. It's not something -- no. I mean, is there any reason? I would say there is no reason that I would do that, because that's not in the scope of my responsibility, so there would be no reason for me to do that. That's like asking me if I would also, you know, practice medicine if I read a couple of books. No.
Q. It's not because -- well, are you saying that the acquisition costs for drugs are not relevant to your job responsibilities?
MR. COCO: Objection.
A. No, I didn't say that either. What I'm saying -- I'm answering your question, which is, you're asking me to read an article from ten years ago on a document that I had not seen and make a bunch of assumptions which I'm not willing to make.
Q. My question to you was, is there any reason why you couldn't go out and do what this reporter did? Your answer to me was that there's no reason for you to do that, because this is not

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relevant to your job. And since this is about acquisition costs for drugs, my question is, are acquisition costs for drugs relevant to your job?
MR. COCO: Objection.
A. Average wholesale price is what's relevant to my job.
Q. What about acquisition costs for drugs, are those relevant to your job?
MR. COCO: Objection.
A. No.
Q. So, you don't care what providers pay to acquire drugs. You're focused only on the AWP.
MR. COCO: Objection.
A. I would say it's not that I don't care.
Q. Let me put it another way. It's not relevant to you in your work in provider relations what providers pay to acquire drugs.
MR. COCO: Objection.
Q. Is that your testimony?
A. It's relevant only to the extent that there's a reason that I should be concerned about it. Again --

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Q. Is there --
A. -- as I said before, I'm assuming that all of these are reasonable rates that are paid. Okay. And if I felt that they weren't reasonable, then I would probably want to go out and do the work that you're referencing here, because there would be a reason for me to want to explore this further. But there really isn't.
Q. Well, if you had read this article in 1996 saying, "Published average wholesale prices is wildly above the wholesale price available to almost any buyer," would that have supplied a reason for you to investigate acquisition costs further, if you had read it at the time?
MR. COCO: Objection.
A. I don't know what I would have done at the time.
Q. And similarly, if you had read the 1992 OIG report saying AWP is not a reliable indicator of the cost of a drug to physicians, would that have provided a reason for you to inquire into the acquisition cost for drugs?

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MR. COCO: Objection.
A. I think as I said earlier, I don't -- I don't know what I would have done in 1992 had I read that. I didn't read it. So, I know that I didn't -- you know, I'm not -- I can't read today with a lens -- I can't read a document that old with today's lens. It's just not relevant.
Q. Let me ask you another question. Are you familiar with WAC or wholesale acquisition cost?
A. No.
Q. You've never heard that term?
A. WAC, W-A-C?
Q. Right, wholesale acquisition cost.
A. No, not that term.
Q. Are you aware that wholesale acquisition cost is another pricing number that's published in the Redbook?
MR. COCO: Objection.
A. I don't -- no, I don't read the Redbook, so I wouldn't know what's in it.
Q. Let me ask you about a specific drug

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now. Are you familiar with the drug Remicade?
A. I don't know what the specifics are. I think it's -- actually, I'm not sure if it's to treat arthritis or something.
Q. Yeah, Remicade is an arthritis drug that's manufactured by Centocor, which is a subsidiary of Johnson & Johnson,
A. Okay.
Q. Now, I would ask you to assume that both the wholesale acquisition cost, which is the WAC, and the AWP for that drug are published in price reporting services such as Redbook, okay?
MR. COCO: Objection.
A. I'm not going to --
Q. I'm asking you to assume it as a basis for a question.
MR. COCO: Objection.
A. I can't assume it, because it's not -- I don't -- I can't assume that.
Q. You can't assume anything?
A. If you're telling me that that's --
Q. I'm telling you.

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A. If you are telling me that, then okay.
Q. I'm telling you, and I'm asking you.
A. I have no knowledge of that.
Q. I'm telling you, and I'm asking you to assume that to be true.
A. Okay.
MR. COCO: Objection.
Q. Okay.
A. Okay.
Q. Now, I'll represent to you that physicians purchase Remicade at a price that's at or around the wholesale acquisition cost, which is a published number, and reimbursement, when it's tied to AWP, that AWP is also a published number. My question is what -- well, let me give you another piece of information: The AWP for Remicade is 30 percent above the wholesale acquisition cost for Remicade, okay?
MR. COCO: Objection.
A. If you're telling me that.
Q. Yeah.
A. Okay.

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Q. So, the differential between the price at which payers acquire -- withdraw that. The differential between the price at which physicians acquire Remicade and the price that they are reimbursed for Remicade is approximately 30 percent, okay?
MR. COCO: Objection.
A. Okay.
Q. In that situation, is that a differential or a margin that you would consider reasonable or unreasonable?
MR. COCO: Objection.
A. I have no basis to know whether that is or not.
Q. Well, you're aware, aren't you, that you're the director of provider relations for a company that's accusing Centocor and Johnson & Johnson of having committed fraud in relation to its pricing of Remicade. So, my question is, do you have any position as to whether or not the pricing of Remicade is fraudulent?
MR. COCO: Objection.

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A. Our -- again, my knowledge would be the AWP price, and in a -- and can go on from there. You're introducing a term that I'm not familiar with around this WAC.
Q. Let me ask you --
A. So --
Q. -- to then simply understand that the actual acquisition costs are 30 percent below the AWP --
A. Uh-huh.
Q. -- for Remicade, and that that number, the acquisition price, is actually publicly available. It's published.
A. Uh-huh.
Q. In that situation, is Centocor committing fraud, in your opinion?
MR. COCO: Objection.
A. I'm not a lawyer. I can just tell you that we expect fair and reasonable reimbursement.
Q. Okay. Expecting --
MR. COCO: Again --
Q. I'm sorry. I thought you were done.

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Are you not?
MR. COCO: Adeel, let me complete my sentence as well. The record doesn't reflect it, but there are times when you start getting on a roll with your questions, and you are cutting off the witness before he has completed a sentence --
MR. MANGI: I strongly disagree with that, but I'm happy to wait for the witness to complete his answer.
MR. COCO: And you just did it now.
MR. MANGI: I did it to you, but I haven't done it to the witness.
MR. COCO: For the record, I would just ask that you pause to make sure that the witness is done completing his answer before you proceed to the next question.
MR. MANGI: That's fine. I interpreted from the witness's pause that he was done. If he wasn't done, I apologize.
Q. Were you done?
A. The point I was going to finish with is, separate and apart from numbers which are, you

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know, is this reasonable, is this not reasonable, this is a business that we're in where 1 percent margin, 2 percent margin that people are making is make or break between staying in business and going out of business. So, in that context, again, what's reasonable? Reasonable is in the eyes of beholder. And in the context of drug or drug prices, I don't know if that's reasonable or not. I'm not qualified to make a determination in my role as director on the reasonableness of that question.
Q. Do you personally, as the director of provider relations, feel misled about anything Centocor did around the pricing of Remicade?
MR. COCO: Objection.
A. If you're asking me personally, a 30 percent differential would not seem to be reasonable. Again, 1 to 2 percent, 3 percent margins that we're talking about in the business that we're in is different than a double-digit.
Q. Now, so -- and a double-digit margin you're saying would be unreasonable whereas 1, 2,

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3, 4 percent would be reasonable?
MR. COCO: Objection.
A. I'm not going to qualify it. I'm just -- in the example that you're using, given the difference in the pricing that you're talking about, that, again, I don't have direct knowledge of, just answering your assumptions.
Q. Are you aware that the position you just stated is flatly inconsistent with the position that the Plaintiffs', Blue Cross Blue Shield of Massachusetts, and others have taken in this litigation? Are you aware of that fact.
MR. COCO: Objection.
A. I would have no knowledge of what's in the --
Q. Are you aware that the Plaintiffs in the litigation --
MR. COCO: Again, he did not finish.
MR. MANGI: He was clearly done with that answer.
Q. Were you -- did you have something more to say?

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A. No.
Q. Okay. Now, are you aware that the Plaintiffs in this litigation have taken the position that the market has long known that there is a differential between acquisition cost and AWP? Are you aware of that fact?
MR. COCO: Objection.
A. Am I aware of what fact that --
Q. That the Plaintiffs have taken the position that it's been long known in the marketplace that there is a difference between the price at which providers acquire drugs and AWP?
MR. COCO: Objection.
A. Not of the specific details, but I can -
-
Q. Are you --
A. -- I understand what you're -- I understand.
Q. Are you aware of the fact that they've taken that position?
MR. COCO: Objection.
A. Unless I -- no, not specifically.

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Q. Are you aware of the fact that Plaintiffs have taken the position that any spread, up to and including 30 percent, is fully within the market's expectations and is not misleading or fraudulent?
MR. COCO: Objection.
Q. Are you aware that they've taken that position?
A. No, not aware. Not aware.
Q. Does that cause you to reconsider any of the testimony you've given so far?
A. Absolutely not.
MR. COCO: Objection.
MR. MANGI: Let's mark the next document. What are we up to?
COURT REPORTER: Exhibit Fox 011.
(BCBSMA-AWP-12613-12614 marked Exhibit Fox 011.)
Q. Take a look at that document and let me know when you're ready.
A. (Witness reviews document.) I'm familiar with this.

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Q. All right. Now, this is a memo in which you are a cc, right?
A. That's right.
Q. The second page of it under "Action Items," it says, "Steve to work with Gary Shramek and Kim Olson on AWP issue." What is that referring to?
MR. COCO: Objection.
A. I don't know, actually, the only issue that I would have worked on were drugs that did not have assigned value because they were recently FDA approved. That really would have been the only thing I would have been tasked with.
Q. If you have a look at the paragraph to which this action item pertains, you'll see it's titled "Pharmacy."
A. Yes.
Q. One of the entries there says MASCO voiced a dissatisfaction with AWP minus 5 percent for chemo RX." Do you see that?
A. I see that, yes.
Q. Was that related to the AWP issue you

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were tasked with working on?
A. No. My issue would have been, again, prior to that, "Discuss new drug process," the feeling was that if a new agent is listed in the compendium, it should be reimbursed. Our policy at the time was not to pay those claims because they did not have an assigned value. It then says -- the one that you're referencing says, "Also discussed yearly development and reimbursement and MASCO voiced dissatisfaction with that." That's not necessarily my action item.
Q. Are you aware that for a period of time Blue Cross Blue Shield of Massachusetts served as a Medicare carrier for Massachusetts?
A. I am aware of it.
Q. Did you have any involvement with Blue Cross Blue Shield of Massachusetts' work as a Medicaid carrier?
A. No, I did not.
Q. Do you know who was in charge of the carrier operations for Blue Cross Blue Shield of Massachusetts?

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A. What year are you referring to?
Q. Well, for what period of time was it the carrier, as far as you know?
A. 1967? I mean, Medicare was formed in 1967. We've been working with Medicare -- I mean, that's what I'm saying is we were a carrier in the '80s, you know, early '90s. But I don't know who was responsible for it. It was not my area. It was a different division.
Q. Do you know when BCBS of Massachusetts ceased to be a Medicare carrier for Massachusetts?
A. Sometime in the '90s. I don't remember exactly when it was.
Q. Do you know of any current employees at BCBS of Massachusetts who did have responsibility for work on the carrier side of the business?
A. No.
Q. Do you know of any former employees who had responsibility for that side of the business?
A. No.
Q. Are you aware that Blue Cross Blue Shield of Massachusetts had a staff model HMO at a

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point in time?
A. Yes.
Q. That was called Medical East Medical West, right?
A. Yes.
Q. For what period of time did BCBS of Massachusetts have that staff model HMO?
A. I don't know how long. Again, I came on board when the staff models were in existence. They were in existence from the '80s.
Q. When?
A. I don't know specific years and dates.
Q. When did BCBS of Massachusetts cease to have a staff model HMO?
A. That was -- we spun off the health centers as a separate corporation probably around 19 -- well, it's ten years. So, it's 1996, probably 1997.
Q. Do you know who at BCBS of Massachusetts, be it current or former employee, would be knowledgeable as to how and/or what prices staff model HMO acquired drugs?

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A. I would have no idea.
Q. Do you know whether or not Blue Cross Blue Shield of Massachusetts contracts with drug manufacturers for rebates pertaining to formulary replacement?
A. Manufacturers?
Q. Yeah.
A. We have a pharmacy benefit manager that does our contracting, but --
Q. Okay. Is that Express Script?
A. That's correct.
Q. Does ESI contract on BCBS of Massachusetts' behalf with manufacturers for rebates?
MR. COCO: Objection.
A. I have no idea what their relationship is or what they do.
Q. Okay. Do you know whether or not, directly or indirectly, BCBS does contract with manufacturers for formulary rebates?
MR. COCO: Objection.
A. Again, we don't contract with

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manufacturers, so I wouldn't have any of that knowledge. We contract with Express Scripts. I don't know what Express Scripts does.
Q. Okay. How many employees does BCBS of Massachusetts currently have?
A. Employees?
Q. Uh-huh. Do you know how many people make up the organization?
A. Over 3,000.
Q. Do you know how many employees worked on the carrier business before it was spun off?
A. No idea.
Q. Do you know whether it was a handful of people or dozens of people?
A. I have no frame of reference. Again, had little to no involvement with that side of our business.
MR. MANGI: Let's mark the next document.
(Group Primary Care Physician Agreement marked Exhibit Fox 012.)
Q. Now, Exhibit Fox 012 is a boilerplate

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contract template, right?
A. Yes.
Q. Now, this particular template says, "Entered into between BCBS --" then there are some more words there "-- on behalf of the Plan's HMO Blue products." Do you see that?
A. Yeah.
Q. Now, were there different templates for different products?
A. Yes.
Q. And how many products does BCBS have in total?
A. I don't know how many products. There are 16 different templates.
Q. There are 16 different templates in existence at the present time?
A. There's probably more than that, but the boilerplate -- 16 boilerplates. Again, largely the same, just different between primary care physicians and specialists, group versus individual, PPO, HMO, indemnity products.
Q. How often do those boilerplates change?

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A. Not frequent.
Q. When you say 16 templates, are you including within that hospital templates?
A. No, just physician.
Q. Just physicians?
MR. MANGI: For the record, we called for the production of 16 templates. We've only received about five.
Q. I'd like you to -- by the way, I asked you earlier -- perhaps you can remind me -- there's only network correct BCBS only has one physician network?
A. I would classify, again, one network.
Q. Turn to clause -- the Section 2.3 of that contract, please. It's on Pages 5 and 6.
A. Uh-huh.
Q. Now, I'd like you to turn over to Page 6, and I'm looking at the last ten sentences of that clause, "Moreover, the group understands and accepts that some or all of the new offerings may involve limited networks."
A. Right.

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Q. What are limited networks?
A. It means in the future we could decide to offer -- a product could be developed that did not require all physicians participating in a given network. So, this boilerplate contemplates the future product offerings.
Q. And has a limited network ever been developed, to your knowledge?
A. No, it has not.
Q. Turn to Section 1.9, please. Page 2.
A. And just for the last point, since you made the reference about the number of boilerplates, the reason that you don't is because the recent changes in Medicare Advantage laws required us to create separate boilerplates for our Medicare business. So, several templates are Medicare Advantage, so, just --
Q. Are those included within the 16?
A. Yes.
Q. How long have there been 16 standard templates?
A. Probably just fairly recently. Fairly

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recently.
Q. Last three years?
A. Last two years, yeah.
Q. How many templates were there in existence before that time?
A. There should just be -- boilerplates? It's largely -- it's this same language, just with different headers. It should be one, two, three -- there should really be four. Again, if you want to say that HMO Blue products, PPO products, and indemnity products are different then, again, four contracts, but there could just be different words at the top. But true boilerplates, there's really only four. The additional ones are really recent. So, I'm sorry. You were asking me to look at what section now?
Q. Actually, I may be able to short-circuit that. I'm asking you to turn to 4.15.
A. 4. what?
Q. 4.15 on Page 6.
A. Okay. Yeah.
Q. Now, this clause describes two types of